Welcome to the 26th edition of the report. Last month, late breaking medical news was the main feature. This month, an exciting look into the future of medicine will blow your mind. I will report on another installment on breast cancer, low back surgery, and type-2 diabetes. The entire subject of headaches will begin with migraines.

**Always know that this report is informational only and not to be used without checking with your personal physicians.** Each person is different, and there are interactions between drugs, and kidney or liver disease may change how your body responds to medications, etc. As the ACA healthcare internet site gets better, I know some of you will be happy and some not. 4 million have signed up, but 20% of those who have signed up have not paid their premium!!!

Be very careful about restrictions of exchanges regarding networks of doctors, hospitals, penalties for going out of network, deductibles, and co-pays. There are platinum, gold, silver, and bronze plans based on cost of premium, and the amount that comes out of your pocket for services. Be sure you know what tier your medications are in, as the cost goes up. My meds are either being dropped from the formulary (Dexilant for reflux) or doubling and tripling in price at a time that is clearly intended to burn those that have multiple illnesses, take
several meds, and see several doctors (I have Humana thru USAA). As expected, the insurance companies and hospitals are taking advantage as is Big Pharma with price increases. You may pay less for your plan, but the cost of meds may wipe out the savings very quickly. Check with your preferred doctors and hospitals before you choose a plan to be absolutely sure they accept your plan. Find out if a regional cancer center is included.

Feel free to share this report with your friends, family, and colleagues.

Subjects for March 2014

A. Type 2 Diabetes—continuation of complications—ketoacidosis/coma
B. Where Obesity begins—age 5!
C. Low Back Pain—most common causes
D. Headaches—understanding the causes; migraine—part 1
E. Breast cancer—atypical ductal and lobular hyperplasia—becoming invasive carcinomas; chemoprevention guidelines; NCI risk factor model for breast cancer
F. Late breaking medical news

A. Type 2 Diabetes—Metabolic Complications—ketoacidosis and coma

The complications of diabetes encompass the entire body's organ systems. Please refer to the archives link on my website for all the complications I have previously covered over the past several months.

The chemical reactions in the blood from glucose are a significant problem for diabetics and frequently are the very cause of admission to the hospital. To understand these metabolic complications, you must understand about the pH of the blood. The pH means the acidity
or alkalinity of the blood. The pH of normal blood is 7.4. Below that, it is acid and above it, is alkaline. The body works hard to keep it at 7.4, by certain adaptive mechanisms, such as breathing faster which drops the carbon dioxide levels in the blood to reduce acidity. In contrast, by breathing less often, carbon dioxide is retained, which increases the acidity in the blood closer to the optimum normal pH. Metabolic acidosis is a dangerous situation for a diabetic.

**Ketoacidosis** is a serious complication and can cause coma and death if left untreated. It is frequently the key reason youngsters are diagnosed with type 1 diabetes. To understand ketones and acidosis, some basic information is necessary. When glucose is sent to the cell by insulin for energy, there is no problem. That is the normal way our body uses energy. When there is not enough insulin secreted by the pancreas, the body looks to the fat cell for energy. Breaking down the fat cells to release fatty acids occurs, and one of the breakdown products of those acids creates ketones, which are acidic and toxic to the body. The liver and brain are especially sensitive to ketones and can easily lead to diabetic coma and death. You can detect ketones in the urine with the Urostick.

For someone on a diet that is healthy and non-diabetic, breaking down fat cells is the normal way a body can lose weight. With adequate hydration and good kidneys, a person can get rid of these ketones without trouble. **Without adequate insulin in diabetics**, the ketones overwhelm the body and cause a multitude of symptoms: thirst, frequent urination, difficulty breathing, a fruity breath, nausea, vomiting, warm flushed dry skin, confusion, feeling very tired, and ultimately lapsing into a coma.

For diabetics, ketones are tested in the urine and blood, and if elevated are a major sign that the diabetic is out of control. This should alert a diabetic to go to the emergency room. This usually requires hospitalization, balancing the pH of the blood, looking for a
cause of the ketoacidosis, such as **infection**. An insulin reaction (causing low blood sugar) or not eating enough food (from a flu bug or other causes of nausea and or vomiting can also cause ketoacidosis). Dehydration is dangerous, and frequently part of ketoacidosis.

Preventing infections are a key reason why diabetics need to be vaccinated against all possible infections (flu, pneumonia, shingles, etc.), and be on the alert for early signs of infection, including kidney, bladder, skin (especially lower legs and feet), and respiratory infections.

Staying in good diabetic control is a no-brainer, but you would be surprised how many diabetics don’t test their blood and urine routinely or even take their oral (hypoglycemic) medications and or insulin. Caregivers must be on the alert about diabetics making sure their diabetes stays in good control. REMEMBER---2 OUT OF 3 DIABETICS DIE OF HEART DISEASE OR STROKE. Reference: American Diabetes Association

**B. When does a concern for Obesity begin? Age 5!**

YES! The New England Journal of Medicine reported:

1) In kindergarten (av. age 5.6 years) ------12.4% obese
   14.9% overweight

2) By the 8th grade (av. age 14.1 years) ----20.8% obese

3) That means 5 year olds that are overweight are 4 times more likely to become obese. Black and Hispanic Americans are even higher. The wealthiest 20% have a lower incidence. Poor families frequently are exposed to more fat and less fruits and vegetables, poor diets, and less activity.

4) If a child is not obese by the eighth grade, there is a much greater likelihood they will not be obese as an adult.
5) The course to obesity is set at 5 years of age. 27.3% enter kindergarten overweight or obese and 50% will be overweight or obese by the 8th grade.

6) 36% of overweight or obese preschooler will be overweight or obese adults.

7) Good news/bad news—the last 5 years, obesity has plateaued topping out at 34%. The rate of 5 year old obese children is dropping for the first time!!!!

8) BMI or waist circumference determines overweight or obese people

9) BMI is height divided by weight (obese = 30 or >) i.e. 5’5” 186 lbs. is obese and 6’0” 221lbs. is obese. Severe obesity is defined as BMI of 35 or >.

10) A most important risk factor is parental weight. If a child has obese parents, 80% will be obese as an adult.) Although genetics are a factor, so is lifestyle factors, good nutrition (eating less fat and 5 servings or more of fruit and vegetables). Over weight parents don’t recognize that their children are overweight, which creates a serious problem, and it makes it harder for them to encourage losing weight. Activity levels of children are decreasing and that is another major factor.

11) Ultimately, the risk for disease increases greatly with obesity in children. Type 2 diabetes, obstructive sleep apnea, behavioral problems, being bullied about their weight, heart disease, breast cancer, colon cancer, gallbladder disease, and arthritis. Type 2 diabetes in children is epidemic because of the weight issue.

12) Prevention as a national healthcare concern has been a difficult issue. Good parenting, education, and exposure to healthy lifestyles are a necessity. The federal government can’t legislate people thin!! Not even in NYC.

C. Headaches—classification; Migraines

Headaches affect us all. But chronic headaches affect millions. The definition of a headache involves the neck secondarily or as a cause. The
classification includes 13 groups of different types of pain in the head, eyes, and neck. Keep in mind the brain and the skull bone have no pain fibers, so the pain comes from the surrounding structures covering the brain, the muscles, fascia and ligaments under the scalp, the sinuses and mucous membranes, the jaw joints, the ear structures, and the vessels throughout the head and neck. To be complete, the nerves that come out of the brain, and cervical vertebrae must be included. When a specialist sees headache patients, the history and physical exam usually narrow the focus of concern rather quickly. Primary care, pediatricians, internists, neurologists, and ENT doctors all see these patients routinely.

There are 6 main sub-categories of headache: 1) primary 2) secondary 3) cranial neuralgias 4) central facial pain 5) primary facial pain 6) other hemi-cranias. I will begin with the primary headaches.

1) The primary headaches are the most common:

   a) migraine  b) tension  c) cluster  d) other---trigeminal neuralgia, autonomic cephalgias, headache secondary to cough, exertion, and sex, etc.

This report will deal with migraines only. Future reports will include the rest of the more common types. Look at the drawing to the right.
**Pathophysiology of a migraine:** Migraines are a neurologic disease. It starts with an electrical firing (cortical spreading depression) in a part of the brain, which communicates with the brain stem. From there, the brain stem communicates with a part of the brain (thalamus), which relays a signal to the sensory cortex of the brain. This causes a reflex of pain fibers to fire on the covering of the brain and vessels. These vessels constrict before they dilate. With the dilation, the pain fibers are stimulated causing the headache.

**MIGRAINES- CLASSIC AND COMMON (WITH AND WITHOUT PRODROMES)**

15% of the population has migraines. Recent research has proven that these headaches are caused by altered brain electrical activity (cortical adaptability in the brain and brainstem). This electrical activity creates inflammation in the lining of the brain (meninges) causing the pain fibers to fire off. Both types of migraines are usually one-sided (but can be both), pulsating in character, lasting 2-72 hours, usually associated with nausea and vomiting, photophobia and phonophobia (increase intensity of lights and sound) with the headache being aggravated by activity. These patients frequently seek a dark room when their headache is severe.

There are 4 phases of a migraine:

1. **Prodrome**—symptoms prior to headache, hours or days—altered behavior, mood, depression, bowel changes, changes in smell, or noise, cravings, stiffness of the neck, euphoria, or fatigue. This may occur hours or days prior to a headache.

2. **Aura**—precedes immediately before the headache usually less than 60 minutes (in women migraines with aura increase the risk of strokes).

1/3 has auras (classic) and 2/3 do not (common). These auras are characterized by:

   a) **visual**—intensity of light, lightning flashes (can be associated with no headache—called migraine equivalents), loss of vision, flickering light, or tunnel vision, b) **sensory**—needles and pins, loss of positional sense, or numbness c) **speech and language** abnormalities, d) **dizziness** e) **motor**
abnormalities—paralysis of parts of the body—hemiplegic migraine usually lasting more than one hour.

3. Pain (rarely no pain)—60% one sided (unilateral) usually, throbbing, moderately severe, comes on gradually, but 40% both sides with pain in the neck, 90% with nausea and/or vomiting, desire to be in a dark room, and can be associated with pallor, sweating, and frequent urination. Tenderness over the skin where the headache occurs is not infrequent with pulsation of the artery just above the ear in the temple. These can frequently happen on the weekend when the stress is off.

4. Postdrome—this final phase can last for hours or days with tenderness where the headache occurred with fatigue, “hung-over”, head pain, cognitive thinking difficulty, gut symptoms (diarrhea or constipation), weakness, moody, however some feel very refreshed, euphoric, or tired.

Next month, I will report on other characteristics of migraines, causes, associations, and treatment options.

D. Breast Cancer--Atypical breast hyperplasia, Ductal and Lobular Carcinoma in-situ, and concern for a second cancer in the other breast; chemoprevention options

This is the third installment on breast cancer. I have reported on the symptoms, workup, and the stages with treatment options. Of course, each case is different, and in the end, a tumor board of doctors should decide the exact treatment. Treatments may change depending on the way the tumor responds to the specific treatment. Chemo may be given before definitive surgery or after. Radiation may be given first to shrink a large tumor, and follow up treatments depend on the genetic markers in the cancer cells (estrogen or progesterone positive or negative, HER positive or negative). There is some controversy about in situ (DCIS) cancers about how aggressive the treatment needs to be. Current research is creating new thinking. Here is a classification:
Anatomy—Note the ducts and lobules of the breast. The ducts drain the fluid and milk with pregnancy from the lobules to the nipple.

Most cancers go through an evolution from normal to precancerous (dysplasia) to in situ to invasive cancer cells and then spread to lymph nodes and spread to studies distant organs (lungs, liver, brain, and bone). The
extent depends on how quickly intervention occurs. Remembering the anatomy of the breast, these tumors begin in the ducts or the lobules of the breast (see diagram). Recent have clarified that both ductal and lobular hyperplasia are a pre-malignant lesion and therefore should be treated as such.

The promotion of over-diagnosis from performing mammography too often has arisen in the news because these cancers tend to be less aggressive and therefore don’t necessarily need to be treated in the pre-malignant stage in some minds. Recent studies have shown that these need to be treated as early as possible to prevent invasion of the breast tissue.

The other concern is in the other breast! Studies have shown that these lesions (from a benign biopsy to cancer) occur within 5 years in 30-40% of the cases. The rest arise over the next 15+ years. Also 21-31% of these malignancies have nodal spread, when diagnosed. The UPTFS (feds) seem to be thinking about the cost instead of the patient’s welfare. Since this is controversial, picking a real expert is critical. Going to a major cancer center also is a very good idea.

This is important for the sake of the controversial information coming out in the news primarily from federally funded studies.

Chemoprevention—because there is a significant likelihood of the other breast transforming into cancer over the years, chemoprevention should be considered with Tamoxifen or Raloxifene for 10 years, just as the other estrogen positive cancers of the breast are treated. This is an alternative to a second mastectomy. The American Society of Clinical Oncology (ASCO) recommends 5 years of Tamoxifen following breast cancer treatment to prevent a second cancer (recent studies recommend 10 years). These anti-estrogen drugs are very successful in preventing recurrence and a second breast cancer (50% reduction). It could save a woman a second mastectomy.

Also, there are good studies that prove Aromatase inhibitors (Arimidex, Aromatase, Femora) can also reduce a second breast cancer. One study from Australia reported 50% reduction in a second breast cancer, and a reduced number of gastrointestinal cancers in patients with estrogen positive cancers. They also do not increase the risk of uterine cancer that Tamoxifen
does. These drugs must be taken for at least 5 years. For now, ASCO does not recommend aromatase inhibitors yet. It is hard to convince women to take these drugs for so long, but they can have a tremendous benefit and prevent a second mastectomy. These are only for high risk groups. A high risk group is defined as a woman with a 3% chance of developing a second cancer.

This is new information having just come out on Feb 5 in the Journal Cancer Prevention Research and from the most prestigious oncology society (ASCO).

These patients must consult a high risk breast cancer expert for the best information!!! Every woman should take this NCI risk tool!

![Breast Cancer Risk Assessment Tool](image-url)
1. Does the woman have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or has she received previous radiation therapy to the chest for treatment of Hodgkin lymphoma?

2. Does the woman have a mutation in either the BRCA1 or BRCA2 gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer?

3. What is the woman’s age?  
   *This tool only calculates risk for women 35 years of age or older.*

4. What was the woman’s age at the time of her first menstrual period?

5. What was the woman’s age at the time of her first live birth of a child?

6. How many of the woman’s first-degree relatives - mother, sisters, daughters - have had breast cancer?

7. Has the woman ever had a breast biopsy?

   7a. How many breast biopsies (positive or negative) has the woman had?

   7b. Has the woman had at least one breast biopsy with atypical hyperplasia?

8. What is the woman’s race/ethnicity?

   8a. What is the sub race/ethnicity?

[Calculate Risk]
E. Low back pain—major causes and management

Please review my previous reports on the anatomy of the lower vertebrae—lumbar and sacral. The fuse in the formative years, and essentially fill the gap of the pelvic bone. Note that the spinal cord has separated into multiple nerves, and each pair will find its way into the individual vertebral canals (shown on the next page). As the spinal cord reaches the lower lumbar and sacral vertebrae, these nerves become more separate nerves in the spinal canal are called the cauda equina ("horse tail"—see labelled drawing next page). The sciatic nerve is made up of the lower lumbar and the sacral nerves. Pain in the hip and down the leg is called sciatica.
There are several common causes of low back pain:
1. **Muscle and ligament injuries**—these are the most common and heal by themselves in days to weeks depending on the severity. Rest, anti-inflammatory meds (i.e. Aleve), muscle relaxants (Flexeril—a prescription), ice early followed in a few days by alternating heat and cold are all recommended.

2. **Disc Injuries**—rupturing a disc reduces the space between vertebrae and the disc squeezes against the spinal cord and or the nerves as they leave the spinal cord in the intervertebral canals. This causes inflammation and pressure on these nerves causing sciatic pain into the buttocks and down the leg, back pain, numbness and tingling down the leg. This pain will persist longer and will likely motivate you to see your doctor. Conservative therapy over time may settle the inflammation down and the other symptoms may or may not resolve. If they don’t, X-rays and or MRI may be required. Pain management from a specialist to perform an epidural steroid injection at the level of the disc rupture is a good consideration.

This drawing shows the nerve root coming out of the spinal cord is being pinched too tight by a smaller canal. This creates pain into the hip and leg.
3. **Osteoarthritis**—affects the vertebrae (as seen above) and the joints (facets) between the vertebrae where they meet each other. These are common causes of long term relapsing pain brought on by lifting heavy objects, weekend warrior activities, or being too sedentary. Arthritis meds (Celebrex, Indocin, Voltaren, Aleve, etc.) may be very helpful. Arthritis causes a lot of stiffness in the morning and likely other joints are involved. This is the wear and tear type of arthritis. Back exercises, yoga, stretching, physical therapy, acupuncture, chiropractic manipulation, etc. all may help. **Facet injections** with steroids from a pain management specialist will help. This is chronic condition will likely never go away, but exercise, stretching, etc. may keep you close to pain free most of the time.

4. **Osteoporosis** of the bones from loss of calcium and strength in the bones leads to fractures and will be covered in the near future.
5. **Spinal stenosis**—arthritic spurs and or disc herniation can protrude into the spinal canal **pressing on the spinal cord**. This will gradually worsen requiring intervention, first with pain management and ultimately surgery. It is more dangerous in the neck. Low back spinal stenosis causes sciatica, and if it worsens, weakness and or numbness and tingling can occur. Late signs are bladder and bowel dysfunction. Spinal stenosis is frequently accompanied by impingement of the intervertebral canal where the spinal nerves are pinched. Although dangerous, it is much more serious in the neck. There is a correlation between cervical and lumbar spinal stenosis. Although pain from a pinched nerve (as the nerve comes out of the canal into the body) can be very serious, pressure on the spinal cord can cause paralysis, bladder and bowel malfunction. Pressure on these nerves occurs over the years, but a superimposed injury from a fall or auto accident can be accelerate this process. Surgical considerations must be based on symptoms but also prevention of serious complications.

The drawings below depict the pressure of arthritic vertebrae pressing on the spinal cord. This drawing on the left shows a very extensive amount of disease. Intervention would likely need to be addressed long before it would be this serious. On the right, the spinal nerve is pinched, represented by the red portion of the nerve, which would swell and become inflamed.
6. **Scoliosis, spondylolisthesis, and spondylosis**—scoliosis is congenital and leads to chronic problems all a person’s life. There is twisting of the spine and can require (Harrington) rods to be placed part of the length of the spine for correction. This requires a specially trained orthopedic surgeon. Spondylolisthesis implies laxity of the ligaments supporting the spine allowing the vertebrae to slide forward and out of place. This may require surgical correction because it is usually associated with pinched nerves, spinal stenosis, etc.
7. **Ankylosing Spondylitis** (as opposed to spondylosis) (see drawing on previous page)
   This usually starts in young people in their 20s, with pain, stiffness, bony fusions of the vertebrae, and tendonitis of tendons and ligaments such as the Achilles tendon. Spondylitis is a type of arthritis like rheumatoid. It occurs much more commonly in men. It creates a classic stoop position.
8. **See your doctor if:** a) pain is not better in 10 days b) your pain is associated with trauma from a fall or car accident c) numbness and tingling with pain is radiating into the hip and/or down the leg. It is especially important if there are any changes in bladder or bowel function d) you have a history of cancer, osteoporosis, immune disease, or over 70 years of age.

Referral to an orthopedist or neurosurgeon may be necessary with X-rays and MRI of the spine, which can be performed prior to seeing a surgeon. My personal preference for neck problems requiring surgery is a neurosurgeon. For other vertebrae, both are fine.

Issues that increase and or aggravate back pain: a) overweight b) poor daily habits c) occasional workouts and yard work with poor mechanics when lifting, posture, sedentary, no regular stretching or exercise, and stress or depression. Not sleeping on a high quality mattress is asking for trouble, and smoking (weakens bones and tissues).

It has been medically proven that chiropractic care, massage therapy, physical therapy, yoga, acupuncture, pain management with epidurals, facet blocks, trigger point injections, relieving stress, may all help low back pain. The key is to have guidance from your doctor based on the diagnosis and severity of the condition. Prevention is always the best way to deal with low back pain. Be smart about your back, and you might not wind up with a scar on your back. If it comes to that, there are different choices for surgery. Next month, I will report on the options for surgery.

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**F. Late breaking medical news**

1) The **U.S. Human and Health Resources Dept.** announced that they will allow patients direct access to their laboratory results, superseding any state laws prohibiting it. This will empower the patient to be more responsible for their healthcare, but it still means you must you must either go see your doctor for what the results mean, or in the future have that consultation on the internet or phone.
2) Bigger hospitals are getting paid 130% of Medicare fees compared to smaller hospitals (77%). You might imagine that competition among hospitals is at an all-time high. There are many factors that go into these levels of reimbursement. The number one reason stated by the IBJ company (that I follow regarding Indiana Healthcare) is the size of their marketing department and how aggressive they are! You didn’t want to hear that, and neither did I. I can understand that teaching hospitals and primary centers harnessed with indigent care might get better reimbursement, but with the new healthcare laws, all those indigent patients will have Medicaid, which will have the hospitals licking their lips. Even the emergency rooms are seeing more (not less) patients. (Obama said his healthcare reform would unclog the emergency rooms—wrong). In fact, the lawyers, the insurance companies, and Big Pharma, all stand to make more money than ever. But, the doctor will get the short end of the stick. That will affect your healthcare experience.

3) CVS will drop cigarette sales later this year primarily because they are increasing the in-store clinics and becoming more health centered. The harder it is to buy tobacco, the fewer young people will buy it (already proven plus the cost of cigarettes reduces youth tobacco use). Walgreen’s has decided not to drop tobacco so far, even though they getting more into medical clinics more just like CVS.

4) There will be more changes with healthcare reform in the next 2-3 years than we have seen in a long time. Brace yourself. It appears to me that the feds are just learning as they go, which is really scary. Rolling out the healthcare.gov website might remind you how well the administration was prepared. It will be interesting to see how long it will take doctors to get paid for these patients. They just extended the time for mid-size businesses (50-
99 employees) to comply with Obamacare to 2016, because the law is making these employers decrease hours of their employees. They learn as they go and they had 4 years to get it right. They will find out they can't save money, which was the reason for the healthcare reform.

5) Stroke risk in women—first ever guidelines! 55,000 more women have a stroke per year than men. Women have risk factors men don't have. For the first time, the American Heart and Stroke Associations have provided guidelines primarily based on blood pressure issues aggravated by female hormones and pregnancy. Migraines with auras, blood pressure issues before pregnancy increasing the risk of pre-eclampsia are additional risk factors. The vascular changes that occur with pre-eclampsia continue throughout life increasing strokes. Taking oral contraceptives and hormone replacement can increase the blood pressure, and with smoking, it increases blood clotting.

Guidelines----monitor all female's blood pressure before starting BCPs or HRTs. Monitor blood pressure carefully with pregnancy, in smokers, those with migraines (with auras), and screen women over 75 for atrial fibrillation of the heart rhythm. A-fib is one serious risk factor for embolism to the brain vessels and stroke. I have reported on A-fib in the past.

Normal blood pressure values have recently changed as pointed out in last month’s report-----120/80 or below. Below are some facts about how important prevention of strokes is:
6) **33 states give more money in welfare benefits than the minimum wage of 40 hours per week** (#1 is Hawaii, which gives them $60,000 which equates to $29 an hour). Now the Congressional Budget Office predicts 2.5 million Americans are essentially being encouraged to quit working since they will have Medicaid or exchange healthcare and “won’t need to work”. And the Democrats are more interested in mothers staying home with their kids rather than work or fulfil their dreams, travel, etc., while the rest of us bust our butts to take care of them. The administration wants to increase the minimum wage. It will cost 500,000 jobs. What happened to improving the economy? Work for what you get? Are we a welfare state? What example is our administration setting? For us to remain a strong society, we must continue to keep the **principles upon which this country was founded.** Hard work equals success, you reap what you sow, nothing is for free, everyone deserves the same chance to get ahead, healthcare is a privilege not a right, making more money means one has to work harder, everyone should provide for their family, this is a country born on Christian principles, English is the language of this country, handouts make people weak, our politicians
represent the people who put them there, there are 3 branches of the
government (executive, legislative, and judicial).......... 

The Congressional Budget Office:

The CBO on Tuesday released a budget and economic forecast in which it estimated that the ACA will reduce
the number of hours worked by Americans by 1.5% to 2% during an 8-year stretch from 2017 to 2024. The
projected drop in hours is "almost entirely because workers will choose to supply less labor" — either
working fewer hours or none at all — as a consequence of obtaining health insurance coverage through Medicaid
expansion or a private plan offered in a state marketplace or exchange. For some, earning too much
could make them ineligible for their ACA benefits. For others, the law would give them the option of taking a
part-time job they liked even though it does not come with health insurance.

The estimated decrease in hours worked will translate into 2 million fewer full-time-equivalent (FTE) jobs in
2017 and 2.5 million fewer FTE jobs in 2024, according

Most people work because it gives them purpose, self-esteem, and a reason
to feel self-sufficient. There are many working poor that can’t afford
healthcare, and I applaud Obamacare for giving them insurance. But many will take advantage of this benefit and become more entitled, dependent, and expect the government to take care of them completely. Is this what we really want? Abuse is so rampant. Please......let us get this country back on the right path.
This completes this report for March, 2014. You are always welcome to respond on my blog (website) or directly to me by email. Stay healthy and well my friends, Dr. Sam

....May your blessings outnumber The shamrocks that grow,

And may trouble avoid you Wherever you go...

Happy St. Patty's Day